REVISED BILL ANALYSIS MANAGED RISK MEDICAL INSURANCE BOARD

Author: Dymally	**Bill Number: AB 2**
Sponsor: Author	**Version: Amended September 7, 2007**
Subject: Major Risk Medical Insurance Program	
Position: Support	

SUMMARY

AB 2 would make the following significant changes in the Major Risk Medical Insurance Program (MRMIP), California's high risk health insurance pool for medically uninsurable individuals, and in the Guaranteed Issue Pilot Program (GIP) that offers guaranteed issue, private market coverage to individuals terminated from the MRMIP after 36 months:

- Supplement the MRMIP's current, capped funding ($40 Million annually from the Cigarette and Tobacco Surtax Fund (Proposition 99)) [Note: The budget reduces this amount to $36 million] with a monthly "per covered life" fee on health care service plans and health insurers sufficient to permit coverage of all eligible individuals, effective January 1, 2009; the Managed Risk Medical Insurance Board (MRMIB) may adjust the fee but it may not exceed $1.50 per covered life absent new legislation.

- Exclude from the definition of "covered lives" those lives in specialized products, such as dental, vision, or Medicare supplement plans, as well as CalPERS and public programs.

- Require health insurers and health care service plans in all markets to either (1) guarantee issue all individual market products at standard rates or (2) pay a broad based fee that would contribute to the costs of the MRMIP.

- Modify statutory language on MRMIP benefits to (1) eliminate the annual benefit cap and includes language that excludes this change from being considered when setting subscriber premiums; (2) provide for maximum lifetime benefits of no less than $1 million; (3) require coverage that is, at minimum, equal to coverage by plans licensed by the Department of Managed Health Care (DMHC) plus prescription drug coverage; (4) include lower subscriber cost-sharing for primary and preventive health services, and for medication to treat chronic conditions; (5) make a six-month pre-existing condition exclusion or alternative three-month waiting period mandatory for certain subscribers; (6) permit deductibles over $500/year; and (7) explicitly refer to disease management and other cost containment strategies.

- Retain the current GIP sunset date of January 1, 2008 for MRMIP 36 month disenrollments, but maintain GIP coverage for existing enrollees until January 1, 2009.

- For 2009, allow those enrolled in the GIP or those disenrolled after 36 months on MRMIP on or after July 1, 2008 to transfer back to the MRMIP without proving they were declined by a carrier.

- As of January 1, 2009, eliminate the 12 month "lock-out" period for MRMIP subscribers who disenrolled from GIP coverage.

- Beginning January 1, 2009, require that individuals newly eligible for conversion or HIPAA coverage obtain that coverage through MRMIB; individuals currently enrolled in conversion or HIPAA coverage may elect to obtain coverage through MRMIP or remain in private market coverage. [This provision was included at the request of the carrier community].

- Eliminate current potential for the program to charge 137.5% of market premiums for plans that have high loss ratios.

- Effective January 1, 2008 through December 31, 2008, allow the program to charge no more than 125% of premiums for comparable coverage for subscribers.

- Effective January 1, 2009, establish program premiums at 120% of market rates for comparable coverage for subscribers with a family income above 300% of the federal poverty level (FPL) and allow 110% of market rates for subscribers at or below 300% FPL.

- Create a MRMIP advisory panel to address implementation of the carrier fee as well as quality and cost-effectiveness of health care for MRMIP.

- Require MRMIB to report to the Legislature by July 1, 2011 on the implementation of this bill.

PURPOSE OF THE BILL

The purpose of the bill is to provide a means of guaranteeing access to affordable, comprehensive health care coverage for persons carriers refuse to insure or "rate up" based on medical conditions.

POSITION AND SUPPORTING ARGUMENTS: SUPPORT

The MRMIB Board has taken a support position on AB 1971 (2006-07 Session) and on an earlier version of AB 2 (2007-08 Session) which contained substantially similar provisions to this revised version of AB2. Staff has yet to bring the Board an analysis of the revised version of AB2.

AB 2 offers a long term, stable solution for providing health coverage to all medically uninsurable persons willing and able to purchase it. A solution now is essential: 1) The GIP – a pilot program in which MRMIP subscribers lost eligibility after 36 consecutive months and instead could purchase guaranteed issue health coverage subsidized jointly by the state and individual market carriers sunsetted on January 1, 2008. Thus, there will be less financing available for coverage of medically uninsurable individuals. 2) Reimplementing the GIP seems infeasible since it A) has already sunsetted, B) results in carrier losses that are not spread equitably across the industry and are borne only by carriers who voluntarily chose to participate in MRMIP. 3) The $40 million capped appropriation for MRMIP has been inadequate, resulting in frequent waiting lists over the past 15 years and repeated opening and closing of enrollment. The funding and access instability discourages eligible individuals from applying. 4) Even with the infusion of carrier funds under the GIP, the MRMIP had to re-impose a waiting list for coverage in May 2006, and further reduced reduce enrollment through attrition. Between May and September, 2006, the waiting list grew to over one thousand individuals. A one-time appropriation of an additional four million dollars in 2006 permitted MRMIB to offer enrollment to everyone on the MRMIP waiting list but this infusion of funds was a temporary measure. 5)

Recent budget reductions have required the MRMIB to reduce the MRMIP enrollment cap. The MRMIP lost $18.3 million in the 2007 Budget Act and the Governor's 2009-09 Budget Proposal calls for further reductions of $4 million [Note: It reduces this amount to $36 million]. This will require the MRMIP to serve fewer than 8,101 subscribers in 2008-09 and result in recurring waiting list. Recent experience has shown repeated closures and reopening of MRMIP enrollment but reduced funding will make the closures more frequent and longer in duration.

The AB 2 approach is consistent with principles the board adopted at its March 22, 2006 meeting.

- It provides sufficient funding to make comprehensive health coverage available to all medically uninsurable individuals who are willing to purchase it.
- It eliminates annual benefit caps that result in cost-shifting to medically uninsurable individuals and thereby makes benefits in the MRMIP more compatible with the needs of the target population.
- It spreads the cost of subsidizing coverage for high-risk individuals across all health insurers and health care service plans in the group and individual market so that the ultimate cost does not fall disproportionately on a small number of health insurance purchasers.
- It addresses premium affordability to some extent by reducing premium levels and establishing tiered premium rates by income level.
- By allowing individuals still in GIP coverage to return to MRMIP, it provides them consumer choice of health plans within MRMIP.

BACKGROUND AND LEGISLATIVE HISTORY

The MRMIP and the GIP

The MRMIP is a high risk health insurance pool which provides access to comprehensive health insurance coverage for Californians who are unable to obtain coverage in the private individual market because they are considered to be medically uninsurable. The MRMIP, established by Chapter 1168, Statutes of 1989, is administered by the MRMIB, and has been accepting subscribers since 1991. MRMIP subscribers pay monthly premiums at rates significantly higher than standard market rates – between 125 percent and 137.5 percent – for coverage from private health plans and insurers under contract with MRMIB. Subscriber premiums cover 60% of the total cost of the program. The remainder of the program's cost is subsidized through the Cigarette and Tobacco Surtax Fund (Proposition 99).

Because the funding for the program normally has been fixed at $40 million annually ($30 million in the MRMIP statute, $10 million through annual appropriations), the MRMIB has established enrollment caps to ensure that costs do not exceed annual appropriations. [Note: The budget reduces this amount to $36 million] This appropriation has proved to be an inadequate source of funding for the pool and has resulted in long waiting lists to enroll in the MRMIP during much of the MRMIP's existence. Furthermore, in order to avoid even more stringent enrollment caps, the MRMIB has, by regulation, included a $75,000 annual benefit cap in the MRMIP benefit design. While less than one percent of subscribers reach the benefit cap each year, those who do are high-cost individuals who must bear the costs or liability for treatment themselves or forego needed health care. Even though the MRMIP's target population is uninsurable individuals, as defined by plan actuaries, nineteen percent make no medical claims at all and 80 percent have annual claims at or under five thousand dollars.

In response to the previous governor's direction for MRMIB to work with the Legislature and insurance industry to find market-based solutions for extending coverage to this high-risk population, the Legislature and the Governor enacted AB 1401 in 2002 (Ch. 794, Statutes of 2002). AB 1401 established a pilot program, referred to as the Guaranteed Issue Pilot Program (GIP), in which subscribers were limited to 36 consecutive months of enrollment in the MRMIP; after that, they were eligible for post-MRMIP guaranteed issue coverage in the private market. Every health plan and insurer that sold individual health policies in the private market was obligated to offer a statutorily-defined guaranteed issue product to these former MRMIP subscribers. Each GIP product was identical to a MRMIP product, except that the annual GIP benefit cap was $200,000 rather than $75,000. MRMIP and GIP products all had maximum lifetime benefits of $750,000.

Unlike the MRMIP, in which the state pays for most of the losses associated with care provided to subscribers, in the GIP the carriers and the state equally share the cost of any health care costs above the premiums paid by the subscribers. The state's contributions to the MRMIP and the GIP are funded by the $40 million annual appropriation; sharing the cost of the GIP subsidy between the state and the carriers permitted coverage of more individuals with the same appropriation. Under the GIP, carriers contributed approximately $29.3 million through 2005, and were expected to contribute an estimated $17.1 million in 2006. GIP claims for 2006 are being processed and reconciled.

Nevertheless, state costs for the MRMIP and the GIP grew significantly, further reducing the number of individuals who could be enrolled in the MRMIP. Even with the carrier revenue the GIP provided, in May, 2006, MRMIB had to impose a new MRMIP waiting list and a requirement that the total enrollment be further reduced through attrition. Between May and September, 2006, the waiting list grew to over one thousand individuals. In 2006, a one-time appropriation of an additional four million dollars through SB 1702 permitted MRMIB to offer enrollment to everyone on the waiting list. Recent budget cuts and expiration of the GIP have resulted in a MRMIP waiting list in December 2007. The program recently reopened for enrollment in January 2008 due to program attrition. However, the repeated opening and closing discourage applicants and agents from enrolling eligible individuals.

In addition, most GIP participants choose the GIP health plan operated by their previous MRMIP carrier. As a result, plans participating in the MRMIP – especially the MRMIP plan with the greatest enrollment – disproportionately shoulder the industry portion of the subsidy for the GIP; plans in the individual market do not share the subsidy equitably. This disparity provides a disincentive for carriers to participate in the MRMIP.

Premiums within the MRMIP and the GIP appear to be unaffordable for many eligible individuals. Depending on subscribers' incomes, MRMIP premiums range from six to 36 percent of annual income. Annual disenrollment surveys of former MRMIP subscribers show that significant numbers disenroll because they cannot afford the monthly premium (51.1 percent, 45.6 percent, 22.9 percent, and 30.6 percent of those disenrolled in 2003, 2004, 2005 and 2006, respectively).

GIP premiums are more expensive than MRMIP premiums; they are statutorily fixed at 110 percent of premiums for the comparable MRMIP products, which is approximately 135 percent of the standard commercial individual rate for a MRMIP equivalent package. This pricing appears to have affected enrollment in GIP plans. Of the first and largest group of individuals disenrolled from the MRMIP – 9,140 on September 1, 2003 – only about 75 percent initially enrolled in GIP coverage. By June, 2005, only 58 percent of all GIP-eligible individuals were enrolled in a GIP plan. While 41 percent of "GIP decliners" in a 2005 survey said they had

obtained other coverage through a job or a spouse, 53 percent said they could not afford the monthly premiums. Participants in the survey were not limited to one reason. It is not known whether the coverage purchased by "GIP decliners" was satisfactory or adequate.

The legislation creating the GIP sunsetted on January 1, 2008 and MRMIP ceased the 36 month disenrollments September 30, 2007. However, under current law, GIP plans must continue to provide coverage to existing GIP subscribers and the costs over and above subscriber premiums are shared by MRMIB and the plans. In addition, there is a twelve month "lock-out" period from MRMIP for GIP subscribers who voluntarily disenroll from GIP plans.

Recent Legislative History

In 2002, AB 1401 established a pilot program, referred to as the Guaranteed Issue Pilot Program (GIP), in which subscribers were limited to 36 consecutive months of enrollment in the MRMIP; after that, they were eligible for post-MRMIP guaranteed issue coverage in the private market. Every health plan and insurer that sold individual health policies in the private market was obligated to offer a statutorily-defined guaranteed issue product to these former MRMIP subscribers. Each GIP product was identical to a MRMIP product, except that the annual GIP benefit cap was $200,000 rather than $75,000. MRMIP and GIP products all had maximum lifetime benefits of $750,000.

In 2006, the California Legislature considered AB 1971 (Chan), which would have supplemented MRMIP's capped appropriation with a monthly "per covered life" fee on health insurers' and health care service plans' insured, "administrative services only" and "leased network" lives. MRMIB supported AB 1971, as did consumer groups (Health Access, AARP, Older Women's League), and the California Medical Association. Several carriers supported some versions of AB1971: Blue Cross of California, Blue Shield of California, Kaiser and Health Net. The carriers that supported AB 1971 have significant individual market business; three (Blue Cross, Blue Shield and Kaiser) are participating carriers within MRMIP. Opposition to AB 1971 included carriers not participating heavily in the individual market, such as Aetna, Cigna, and Pacificare.

AB 1971 failed passage. However, the Legislature passed, and the Governor signed, SB 1702 (Ch. 683, Statutes of 2006). SB 1702 (1) appropriated an additional four million dollars to MRMIP in 2006 and (2) extended the GIP sunset date to January 1, 2008. With a January 1, 2008 sunset date for the GIP, MRMIB did its last 36-month MRMIP disenrollments on September 30, 2007.

Following the introduction of this bill (AB 2) in 2007, the Governor called a Special Legislative Session on Health where ABX1 3 (Dymally) was introduced. The bill is substantially the same as AB 2: it requires health plans and insurers licensed in California to either pay a fee towards funding the Major Risk Medical Insurance Program (MRMIP) or guarantee issue coverage to medically high-risk persons. The bill has been in the Assembly Health Committee since November of 2007.

Other States' Information

According to *"Comprehensive Health Insurance for High-Risk Individuals/A State-by-State Analysis,"* published by the National Association of State Comprehensive Health Insurance Plans (NASCHIP), 34 states, including California, administer high risk pools for medically uninsurable individuals. California's MRMIP is one of three state high risk pools that are funded only with state dollars and consequently have enrollment caps. Most states use some form of

carrier assessment to finance their pools. Some states that do not directly fund their high risk pools with state dollars offset a portion of the carrier assessments through state tax credits. Despite California's population, the MRMIP is only the third largest state high risk pool. In 2004, with enrollment of 12,221 MRMIP subscribers and 7,569 GIP subscribers, MRMIP enrollment fell behind Minnesota's (32,959) and Texas's (27,573).

Federal Funding

The federal Trade Act of 2002 provided state high risk pools with funding for two federal fiscal years (FFYs), 2003 and 2004, based on the state's number of uninsured individuals. While California theoretically could have received approximately ten million dollars for each of the two FFYs funded under the Act, California was unable to receive funding because the MRMIP did not meet the statutory criteria for a "qualified high risk pool." The primary reason California could not meet the federal standards at that time was MRMIP's $75,000 annual benefit cap. At the time, CMS had not reached a final conclusion on the benefit cap issue.

Congress did not appropriate additional funds for FFY 2005. In February, 2006, Congress passed, and the President signed, the State High Risk Pool Funding Extension Act of 2006. Simultaneously, the Deficit Reduction Act of 2005 appropriated additional funding for FFY 2006. No funds have been appropriated in FFY 2007 or FFY 2008 but states are lobbying Congress and the President for additional high risk pool funding.

As a result of amendments enacted in the State High Risk Pool Funding Extension Act of 2006, California meets a newly modified federal requirement to accommodate all HIPAA-eligible individuals through a combination of the state's high risk pool and the private market. In 2006, CMS indicated definitively that California still does not qualify for funding because of the $75,000 annual benefit cap. However, without a greater level of funding for MRMIP and greater subsidies for subscriber premiums, lifting the benefit cap significantly would result in even more stringent enrollment caps and higher subscriber premiums.

Because of the $75,000 cap, California did not qualify for the four to eight million dollars that could otherwise have been available in 2006. However, California successfully applied for a federal "seed grant" to help California become a "qualified high risk pool". CMS granted California $150,000 to perform a "feasibility study." The study resulted in the following findings:

1. MRMIP differs significantly from other high risk pools in how it structures and offers benefits to subscribers. For example, more health plan participate in the MRMIP than in other state pools but MRMIP offers only one benefit design while other states offer various coverage packages.

2. Case, disease, benefit and pharmaceutical benefits management techniques are widely leveraged by MRMIP contracting plans, as is the case in other states.

3. While disease and case management programs have been found to improve health status, there is little reliable data on cost savings.

4. Unlike the MRMIP at the time of the study, most high risk pool subscribers in other states have deductibles. The MRMIP has now implemented a $500 deductible that excludes preventative services.

The study also contained key recommendations:

1. Allowing for a greater annual limit may greatly benefit the less than 1 percent of MRMIP subscribers who accrue higher costs and may not required any increase in state appropriations.

2. MRMIB could consider the possibility of high deductible plans which may lower costs for many subscribers but there are serious unanswered questions that should be evaluated.

ANALYSIS

At its March 22, 2006 meeting the MRMIB board adopted the following principles for evaluating legislation affecting the future of the MRMIP:

- Enrollment in coverage for high risk persons should be available to all willing to purchase it.
- The structure of coverage for medically uninsured persons should not provide health plans with a disincentive to participate in the purchasing pool.
- The structure of benefits should be compatible with the medical needs of the population. It should not provide a disincentive for utilizing needed health care.
- The program should be structured and administered in a way to encourage and promote consumer choice of health plans.
- Coverage should be affordable.
- There should be some mechanism to ensure that the diverse population of California is aware of the availability of coverage for medically uninsured persons.

The key provisions of AB 2, described below, are consistent with these principles.

Comprehensive Funding for the MRMIP through Carrier Fees and Subsidies

"Play or Pay"

In order to provide funding for all eligible individuals, the bill would codify MRMIP's annual $40 million "Proposition 99" appropriation and would give health insurers and health care service plans a choice between: (1) guarantee issue all individual market products at standard rates; or (2) paying a broad based fee that would support MRMIP. In both cases, carriers' fees or subsidies would depend on their share of the private health coverage market ("covered lives"), including insured lives (lives for whom the carrier provides or indemnifies health care services), "administrative services only" (ASO) lives, and "leased network" lives. "Covered lives" would not include individuals covered by the California Public Employees Retirement System (CalPERS), Medi-Cal, Medicare, the Healthy Families Program, Access for Infants and Mothers, MRMIP, California Children's Services (CCS), county-based "Healthy Kids" programs, and various specialized or supplemental products. Carriers opting to pay the fee would pay the fee to their regulators: the Department of Managed Health Care (DMHC) or the Department of Insurance (DOI). The two departments already have the infrastructure in place to collect other fees on carriers.

MRMIB would calculate the level of the fee by determining the total amount needed for program costs, including funding needed for individuals previously enrolled in the GIP, net of the state appropriation and subscriber premiums. The fee for each covered life would depend on total program costs and the total number of covered lives for all carriers. The bill would cap the fee at $1.50 per covered life absent further legislation.

Adequate funding spread over the market

Writ large, this arrangement satisfies a key principle articulated by the MRMIB board. Specifically, the assessment mechanism would be based on the full cost of running the program. This approach would eliminate the current capped funding that has resulted in waiting lists and that also has necessitated an annual benefit limit ($75,000), which is incompatible with mainstream, private coverage and a barrier to federal funds. Absent the existing special waiver from DMHC for purposes of MRMIP, the current annual benefits caps would not meet Knox-Keene regulatory standards.

The author's decision to assess group as well as individual carriers is sound; it would spread the fee over the market at large rather than confining it to the individual market. When carriers are assessed, the costs are passed on to purchasers of health coverage. The narrower the base over which the fee is spread, the greater the impact on the cost of health coverage. It seems particularly inappropriate to require purchasers in the individual market, which already is significantly more costly than the group market, to bear the full additional cost that would result from the fee. The scope of the broad assessment in AB 2; includes the revised approach from AB1971 that reinsurers were eliminated from the assessment following discussion with various insurers. The majority of insurers that have supported AB1971 and AB2 insisted on maintaining the ASO covered lives of insurers but some insurers that have never supported either AB1971 or AB2 will oppose that position. AB 2 now excludes CalPERS from the covered lives assessment; this exclusion has received opposition from the California Chamber of Commerce and one insurer. If the provision is removed, CalPERS representatives have indicated that they will oppose the bill. Similarly, the exclusion of reinsured lives, which was discussed at more length during the development of AB1971, had proponents as well as fierce opponents in the insurance industry

Furthermore, group carriers' underwriting behavior has a direct impact on the individual market. Under current law, health care service plans and insurers generally are not prohibited from denying health coverage to individual applicants, with specified exceptions under state and federal law; or from denying coverage to group purchasers with more than 50 group members, based on the demographic characteristics, industry, preexisting health conditions, health history, health status, health service utilization or anticipated risk of health service utilization. In addition, carriers are permitted to charge higher premium rates to individuals and groups based on these factors. Therefore, group carriers' underwriting and rating practices leave groups without health coverage and this, in turn, forces many employed individuals to seek coverage in the individual market.

In conjunction with discussions about AB 1971 (Chan), MRMIB asked PricewaterhouseCoopers (PwC) to analyze the "per covered life" cost of funding MRMIP fully. PwC provided a multi-year analysis based on various scenarios, including narrower and broader definitions of "covered life" as well as inclusion and exclusion of new HIPAA and conversion eligible individuals. Under a covered life definition similar to that in AB 2, the monthly "per covered life" fee for covering MRMIP and former GIP subscribers started at twenty-seven cents in the first year and grew to sixty-one cents in the fifth year. The monthly "per covered life" fee for covering new HIPAA and conversion enrollees and a portion of current HIPAA enrollees started at nineteen cents per month and grew to eighty-eight cents in the fifth year. The combined "per covered life" fee started at forty-six cents and grew to one dollar forty-nine cents in the fifth year.

The significance of separating the cost of MRMIP and former GIP subscribers from the cost of HIPAA and conversion subscribers is that, under current law, individual market carriers already subsidize HIPAA coverage and group carriers already subsidize conversion coverage. Therefore, the fee to cover these individuals would represent a change in form but not a new cost. The primary new cost to carriers would be the portion of the fee attributable to MRMIP and former GIP subscribers. This is important since, as discussed further in this analysis, AB 2 proposes to terminate new private-market guaranteed-issue coverage for HIPAA and conversion eligible individuals, substituting MRMIP coverage. [This provision was included at the request of the carrier community]

MRMIB staff will continue to work with PwC to refine PwC's assumptions and to analyze the adequacy of the fee as the bill evolves.

Fees Under California Law

Under the California Constitution, (Article XIIIA, Sec. 3), taxes must be enacted by a two-thirds vote, whereas a variety of fees may be enacted by a simple majority vote. The Legislative Counsel digest indicates that passage of the bill will require a majority vote. Pairing carriers' obligation to guarantee issue individual market coverage at standard rates with the alternative of electing to pay a fee is consistent with a characterization of the carrier assessment as a fee and not a tax.

Further Subsidies for Subscriber Premiums

Prior versions of this bill allowed the MRMIB to adjust subscriber premiums to reflect subscribers' ability to pay. The board could reduce premium to not less than 115 percent of market rates for subscribers with annual income at or below 200 percent FPL. Reducing premiums from 125 percent of market rates to 115 percent of market rates would continue to require that subscribers pay a substantial percentage of their incomes for health coverage.

In its current version, the bill has been amended to require that, beginning January 1, 2009, subscriber contributions must be 120 percent of market rates for those with a family income above 300 percent of the FPL, while those with a family income at or below 300 percent of FPL would be required to pay 110 percent of the market rate. The revisions do reduce premium levels and do establish a tiered premium rates by income level but may not address affordability issue for the lowest income subscribers because the proposed premium rate structure will continue to require that they pay a substantial percentage of their income for health coverage. It should be also noted that the bill eliminates the $75,000 annual benefit cap and that will significantly subsidize the costs paid by the 1% of MRMIP subscribers who exceed that benefit cost.

Eligibility Changes

The bill would make important changes in MRMIP eligibility:

HIPAA and Conversion Eligible Individuals

The federal HIPAA law requires carriers to sell their most popular individual market products on a guaranteed issue basis to individuals who lose their group coverage and who have 18 or more months of prior "creditable" health coverage. State law requires a group carrier to sell "conversion" products to individuals losing group coverage with that carrier. As a result of AB

1401, conversion products in California are essentially the same as HIPAA products. Both may be sold at above-market rates, but California law limits these rates.

The bill would terminate private market, guaranteed-issue coverage for new HIPAA eligible and conversion eligible individuals and instead would provide eligibility for these individuals in MRMIP. In addition, the bill would permit individuals already enrolled in HIPAA or conversion coverage to remain in their HIPAA or conversion plans or opt into MRMIP. In 2006, carriers advocating for inclusion of the HIPAA and conversion populations in MRMIP argued that all three populations (MRMIP, HIPAA and conversion) were similar and should be treated similarly. In addition, carriers already bearing losses for HIPAA and conversion coverage did not wish to bear losses for uninsurable individuals in two different forms, i.e., HIPAA/conversion losses and the new fee supporting MRMIP.

Providing HIPAA and conversion coverage through MRMIP appears to simplify the market for high risk individuals and makes the financing of guaranteed issue coverage for similarly situated individuals more transparent. In some cases, individuals may prefer the coverage available through HIPAA or conversion to the coverage available through MRMIP. By permitting individuals already receiving HIPAA or conversion coverage to choose between their current coverage and MRMIP, the bill addresses this concern. If the bill continues to include HIPAA and conversion coverage in MRMIP, it is important to understand that, as discussed above, a significant portion of the carrier fee is not a "new" cost but rather a substitute for the losses carriers currently bear as a result of HIPAA and conversion coverage.

Return of GIP Subscribers and Disenrollees

Instead of continuing to provide private market coverage to MRMIB subscribers who have been terminated pursuant to the GIP, the bill would amend existing law to re-incorporate GIP subscribers into MRMIP as of January 1, 2009. The bill also would require MRMIB to provide notice of the upcoming sunset of the plan requirement to continue providing GIP coverage to all former subscribers who were terminated pursuant to the GIP and would require GIP carriers to send current subscribers and those who disenrolled after a specified date an informational notice produced by MRMIB to inform them of their rights to return to MRMIP.

Elimination of the GIP is consistent with the board's principle that coverage should be available to everyone willing and able to purchase it; the GIP "stretched" the capped state appropriation but ultimately did not raise enough funds to make coverage available to all eligible individuals. In addition, elimination of the GIP is consistent with the board's principle that coverage should be affordable; there is evidence that high GIP premiums limited GIP enrollment. The proposed provisions for terminating the GIP appear administratively sound; the notice requirements provide GIP subscribers with information that should minimize disruption during the transition.

Modification of MRMIP Benefits

The bill would eliminate any annual cap on benefits and includes language that excludes this change from being considered when setting subscriber premiums. The bill also would require a lifetime cap on benefits of no less than one million dollars and would make a six-month pre-existing condition exclusion, or alternative three-month waiting period, mandatory for subscribers other than HIPAA and conversion-eligible individuals or those who had prior coverage within specified time periods. In place of the current statutory maximum deductible of $500 annually with an exclusion for preventive services, the bill would no longer specifically limit deductibles but would mandate lower cost sharing for preventive services and medications for treatment of chronic conditions.

In addition to bringing the MRMIP into compliance with federal funding standards, elimination of the annual cap complies with the board's principle that coverage in the high risk pool should be compatible with the medical needs of uninsurable individuals. While the MRMIP's $75,000 annual benefit cap, imposed by regulation, is a means of living within a capped appropriation while avoiding further enrollment limits, it is, in essence, a cost-shift to those unlucky individuals who have medical expenses above $75,000 annually. These individuals must bear the cost or liability for services above $75,000 or must go without needed health care, while continuing to pay their MRMIP premiums in order to retain eligibility for the following calendar year.

For those who must forego necessary medical services or who receive needed services but are unable to pay, the result may be devastating. Recent media coverage has emphasized that health care costs are a predominant cause of personal bankruptcy in the United States. Increasing benefits by eliminating the annual cap will increase subscriber premiums but will spread the costs of medical care more evenly among all MRMIP subscribers: those few whose medical needs now exceed the annual benefit cap and those whose medical costs are below the cap.

The requirement in AB 2 that MRMIP coverage include a lifetime cap on benefits of no less than one million dollars is more compatible with benefits sold in the private market than the current $750,000 lifetime limit. Making the six-month pre-existing condition exclusion, or an alternative three-month waiting period, mandatory is compatible with products currently sold and limits the fee the carriers may be required to pay. Currently, MRMIP imposes a three-month pre-existing condition exclusion or waiting period.

Increasingly, products sold in the commercial individual market include high-deductible health insurance products. The bill does not require MRMIB to sell such products but removes the limit on deductibles. This gives the board authority to investigate whether such products serve the best interests of subscribers.

The bill also would make explicit that the MRMIB's authority to establish benefits within MRMIP includes disease management and other cost containment strategies. While the board does not currently lack this authority, making it explicit sets an expectation that the board will explore important issues affecting both the appropriate delivery of health care services to the target population and the cost of coverage for the state and subscribers.

Advisory Body

The bill would create a MRMIP advisory panel to address implementation of the carrier fee as well as quality and cost-effectiveness of health care.

The advisory panel would include eight members: four representing carriers, two representing medically uninsurable consumers, one representing the physician/surgeon community and one representing business. The panel would also include two ex-officio non-voting members: the Director of DMHC and the Insurance Commissioner or their designees. The panel would consider both fee implementation and issues of quality and cost-effectiveness. The MRMIB would be obligated to respond in writing if it rejected a written recommendation from the panel. MRMIB would convene the panel prior to February 1, 2008. The panel composition would provide carriers with an additional opportunity to scrutinize MRMIB's determinations affecting the fee, while providing doctors and consumers the opportunity to scrutinize the adequacy of the fee as it affects quality of care.

Time Lines and Other Technical Issues

This analysis addresses the September 7, 2007 version of the bill. It is understood that, before its enactment, the bill will need modification to ensure that the administrative details and time lines are sound. For example, the bill includes deadlines that occur early in 2008. These were feasible when the bill had the possibility of enactment in 2007 but would have to be updated now.

FISCAL IMPACT

AB 2 would result in several significant program changes that would increase enrollment, premiums and claims costs, as well as administrative costs. As the bill continues to develop, MRMIB staff will analyze the fiscal impact.

SUPPORT/OPPOSITION

Support

American Federation of State, County and Municipal Employees, AFL-CIO
California Alliance for Retired Americans
California Medical Association (CMA)
California Seniors Coalition
Health Access California
Mayor Antonio Villaraigosa, City of Los Angeles
Older Women's League of California

Opposition

Aetna
Association of California Life and Health Insurance Companies (ACLHIC)
California Association of Health Plans (CAHP)
California Manufacturers and Technology Association
California Right to Life Committee, Inc.
Howard Jarvis Taxpayers Association

ARGUMENTS

Pro:

- The bill would provide sufficient funding to make comprehensive health coverage available to all eligible individuals who are willing and able to purchase it.
- The bill would eliminate annual benefit caps that result in cost-shifting to medically uninsurable individuals and would make benefits in the MRMIP more compatible with the needs of the target population.
- The bill would spread the cost of subsidizing coverage for high-risk individuals across all health insurers and health care service plans in the group and individual market – and would include their administered lives as well as their insured lives; this limits the impact on any one group of end users (health insurance purchasers).
- The bill would, to an extent, address premium affordability by lowering existing rates and establishing tiered rates based on subscriber income.
- The bill would remove disincentives for carriers to participate in the MRMIP and thereby promote consumer choice of health plans within MRMIP.

Con:

- The bill would continue the approach (shared by California and most other states) under which individuals pay more for health coverage simply because of health conditions that are generally beyond their control.
- The bill would continue to mandate that high-risk individuals, including those with low incomes, pay higher than market rates.
- Expanding the bill's fee proposal so that stand alone TPAs also are subject to the fee would appear to spread the cost of subsidizing uninsurable individuals more broadly, limiting the impact on any one group of purchasers.

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